Roanoke Valley Health Services, Inc.
"Transforming Primary Care to Improve Health Outcomes"
Application for U.S. Department of Health and Human Services
Health Resources and Services Administration
Small Health Care Provider Quality Improvement Program
HRSA Grant No.: G20RH30545
Primary Contact: Tiffany Mose

FY2018 NONCOMPETING CONTINUATION (NCC) PROGRESS REPORT
Reporting Period: August 1, 2017 – July 31, 2018

Project Progress

a.) Please discuss grant project progress in relation to each funded activity completed during *this previous grant period (August 1, 2017 – July 31, 2018)*. Please include a description which addresses the following areas:
- Fulfillment of current project work plan activities and any respective project goals, objectives and resulting outcomes completed during this previous grant period (August 1, 2017 – July 31, 2018).
- Any needed adjustments and/or modifications to the current project work plan and specification of any resulting project impacts from such adjustments and/or modifications, as applicable. *(Please refer to the most recent HRSA approved project work plan in specifying any adjustments and/or modifications)*.
- *Note:* This response should align and supplement the content submitted for completion of appendices attachment #1.

Please see the comments sections in Attachment 1.

b.) Please describe how the work plan for the *upcoming grant period (August 1, 2018 – July 31, 2019)* will align with the goals of the Small Health Care Provider Quality Improvement Program and include any anticipated programmatic changes, if applicable.
- For any anticipated programmatic changes noted, please also include a brief statement which addresses why described changes are necessary and how, if applicable, these changes may impact meeting project goals and objectives. An updated work plan must also be submitted with this report if any updates and/or revisions to the current work plan are needed for year three project implementation.

The work plan for the upcoming grant period aligns with the goals of the Small Health Care Provider Quality Improvement Program in that it is structured around improving the overall health status of our patients and reducing emergency department visits. The work plan, in conjunction with the PCMH model of care, is the framework for transforming the healthcare services from acute- focused, episodic care to coordinated, proactive and preventive care. The case managers and panel managers are closing gaps in care and educating the patients on the importance of preventative care and appropriate utilization of the emergency department. Outreach continues to be performed to schedule patients for Medicare Annual Wellness Visits and Medicaid Preventative Visits, and enrolled them in the Chronic Care Management program, when applicable.

The case managers continue to receive daily reports of all patients (assigned to our practice) that have been admitted and discharged from the medical center and facilitate the information to the respective panel managers for the provider to which the patients are assigned.

The panel managers then call their patients to discuss information related to care transition and schedule them for a hospital follow-up appointment with his/her respective primary care provider. The urgency of this appointment within seven days is to further reduce the potential for readmission and meet the requirements for the Transitional Care Management (TCM) visit. The work plan focuses also heavily on quality metrics to reduce risk(s) associated with chronic conditions through data extraction and evaluation for the purpose of developing interventions to improve both outcomes and overall health.

The anticipated programmatic change to the staffing plan for year three is to replace the two remaining open, Medical Assistant positions in the Staffing Plan with two Panel Manager positions. Two Panel Manager positions were added to the care teams in the practice prior to being awarded the HRSA grant. These positions were added to support the empanelment of patients and team based approach to care under the PCMH model. The initial staffing planning for the HRSA grant added two additional panel manager positions to both support this effort and the work of the HRSA grant around Chronic Care Management (CCM), promoting Annual Wellness Visits (AWVs) and Medicaid Preventative Visits. At full staffing, the practice has six; full-time providers; which indicates that the team needed two panel managers. Currently, the care management workload for the patient panels of the two additional providers is being shared by the four existing panel managers. In the assessment of overall, clinical workflow, we've learned that the role and functions of the two support nurses in the clinic can be facilitated by a medical assistant. Likewise, the functions and roles of the panel manager to include creating care plans and providing patient education and coordination of activities or services to close gaps and care; must be facilitated by a licensed nurse. Making this change will not only better the PCMH model of having a care team on which each member is functioning at the top of his/her license; but will also allow for both the staffing needed to support the growth of the Chronic Care Management program and increase the capacity for scheduling Annual Wellness visits in a timely manner.

No revisions to the current work plan are needed for year three project implementation.

Staff Vacancies

Please specify any staff vacancies and/or turnover you had during *this previous grant period (August 1, 2017 – July 31, 2018)* and/or *may be anticipated for the upcoming grant period (August 1, 2018 – July 31, 2019)*. Please explain any project implementation that has been significantly affected as a result (or anticipated to be affected) and, if so, how.

Our practice had a few internal employees to apply for and transition into the roles created for the grant program. Cory Dill (RN) transitioned out of the Case Manager position to a specialty nurse position at Halifax Regional. Jeri Hernandez (RN) transitioned the Panel Manager position into the Case Manager position vacated by Cory. Ashleigh Lyons (RN) transitioned from the Panel Manager position to a case manager position (separate from the grant) and then to a nursing position at the local health department. Courtney Mayle (RN) transitioned from Dr. Robert's nurse to the Panel manager Position vacated by Ashleigh. The Panel Manager position vacated by Ashleigh Lyons is a vacant position. While these transitions did not delay any implementation, they did have an impact on productivity due to training. Salary differential and work load were both deciding factors for both nurses who left the practice.

The decision made by the management team during the grant year one to replace vacated nurse positions with clinic assistant positions with either Certified Nursing Assistants (CNAs) or Medical Assistants (MAs) had to be revisited. It was quickly realized, that there was a mismatch between the needs of the Clinic and the skill set and scope of practice of the CNAs, which did not meet the day to day needs of our patients and physicians. As a result, nursing staff had to be pulled from their grant positions to provide direct patient care. During this process we also learned that the scope of practice of Medical Assistants was much broader and better met the practice need, and a subsequent decision was made to replace the CNAs with more MAs. One (of the two) clinic assistant positions for the grant was filled initially by a MA (Heather Miles) and the other was filled by a CNA (Mia Gardner). We were able to recruit another MA, Tiffany Stephens, to fill the second, vacant clinic assistant position. Although recruitment efforts began immediately, the Panel managers had to continue to fill in to cover the patient care needs and continue to cover staffing shortages related to vacation requests and unexpected call-ins.

Challenges, Barriers and/or Unresolved Issues

a.) Describe any significant project implementation challenges, barriers and/or unresolved issues that may have occurred *during this previous grant period (August 1, 2017 – July 31, 2018)*.

b.) Please include in your description an *explanation for how these challenges were resolved and/or steps that are being taken to address these issues.*

c.) Please describe and address any *anticipated challenges/barriers for the upcoming grant period (August 1, 2018 – July 31, 2019)*, as appropriate, and explain how any anticipated challenges/barriers may be resolved or addressed.

The practice has continued to struggle with the reporting capabilities in the new Athenahealth practice management (PM) and electronic health record (EMR) systems. While the information is recorded in and extractable from the system, there are several quality reports for which either the date ranges cannot be manipulated or filters do not allow for isolation of the only target population for the purposes of the grant. Our strategy to approach this barrier has consisted of manual data abstraction and partnering with AXIA, a Management Services Organization (MSO). AXIA has connected our practice with a third party company (J.C. Griffin, LLC) which uses a live data feed (from Athenahealth) to custom generate the reports that we need for the HRSA grant. Additional barriers that our practice has faced include losing a physician assistant to a specialty practice and the resignation of an employed physician. The loss of these two providers reduced our practice's capacity to facilitate the expected number of Annual Wellness Visits and Medicaid Preventative visits. We are actively recruiting to replace these two providers and in the interim, have brought on two locums tenens providers.

Outcomes & Accomplishments

a.) Please provide a list, and include descriptions, where needed, of project outcomes accomplished during this previous grant period (August 1, 2017 – July 31, 2018).

Outcomes provided *must be quantitative* and *demonstrate project impact* on the grant funded target intervention patient populations.

To date the practice has been able to complete 828 Annual Wellness Visits (AWVs), 157 Medicaid physicals; 49 Welcome to Medicare (IPPE), and 179 Transitional Care Management (TCM) visits. The Chronic Care Management (CCM) program requires the greatest FTE investments and, at times, has been the most challenging. There was a period of time near the beginning of year two during which one aspect of the program effort was suspended. The panel managers had to stop enrolling new patients because they had reached their capacity for being able to complete the calls and do the respective work effectively. At that time, they were consistently being pulled to cover other staffing positions in addition to having to share the patient panels of two providers amongst the four of them. Despite the challenges, the panel managers worked together to develop a plan to streamline their work and prioritize tasks. By November of 2017, enrollment of new patients resumed; and the team has enrolled approximately 300 additional Medicare patients and completed a total of 2,298 CCM calls during the year 2 grant period.

The practice has continued to positively affect outcomes and trends in our target population, specifically with the Medicaid population. The data has shown a continued reduction in emergency department visits by the Medicaid patients assigned to our practice from to 98 visits in October 2016 (near the time that the grant was awarded) to 83 visits in November 2017. The changes to the provider appointment templates and an increased focus on patient education have both contributed to the reduction in ER visits. Similarly, the readmission rate for this patient population dramatically has declined. We are working closely with a quality specialist for Access East- Community Care Plan of NC (CCNC) to more closely analyze the data of our Medicaid patients housed in their provider portal. The team has been able to identify the top four chronic conditions of this patient population and make concerted efforts to offer disease-specific patient education and develop care plans with specific goals to improve the patient's health around these conditions. This portal has allowed for the ability to identify high-utilizers of the emergency room, so the panel managers can work closer with those patients to prevent unwarranted visits and inform them of appropriate resources in the community.

The practice successfully attested to MIPS (Merit-based Incentive Payment System) for all providers in the practice for 2017. The National Quality Forum (NQF) provides the framework to measure quality metrics; to quantify healthcare processes and outcomes; and supports the ability of the organization to provide high-quality care. Some of the NQF measures included in the MIPS attestation overlapped quality measures being reported on for the grant project. This is one example of how the focused work and efforts of the grant funded employees have contributed to the overall success of other quality programs, such as MIPS. The PCMH model of care has also contributed to the change in culture and enhanced the efficiency of how the clinical team practices. The model allows us to easily focus on quality initiatives during each encounter with our patients.

The practice was chosen as one of eleven in the state of North Carolina to participate in a five year research study conducted by CMS, called the Million Hearts Model.

The research project used a risk-reduction strategy to study the effects of intentional and targeted treatment plans to reduce the overall risks of a patient developing a heart attack or stroke. There was an interventional group, which we were chosen for, and a control group. The target population is Medicare patients aged 40-79 who've never had a heart attack. This target population overlaps that of the grant funded project. The team enrolled 1,270 patients in year one, of which 307 were determined to be at high-risk for developing one of the debilitating conditions. The challenge, and the way the practice will be paid in year two of this program, is to work closely with the patients to reduce their overall risk scores. The risk score is the quantitative measurement used to determine the effectiveness of the clinician's work. The work includes a shared decision making model between the patient and provider to develop a treatment plan that reduces the patient's overall risk. The practice earned $20,150 in the first six months of year one of the program and anticipates approximately $17,000 from the work done in the second half of the year. Much of this work involves shifting the focus to quality initiatives, including blood pressure and cholesterol control.

b.) Please include a list of any additional major project accomplishments, either quantitative or qualitative in nature, and describe its significance to your project and/or target intervention population that have occurred during *this previous grant period (August 1, 2017 – July 31, 2018).* This may include awards, national, state or local recognition, major milestones, economic impact project, etc. Please include in this description an explanation of how these noted accomplishments impact and/or are reflective of project goals.

Roanoke Clinic recently completed a recertification survey to maintain its Rural Health Clinic status. The survey was conducted by a representative from the Department of Health and Human Services. The survey occurs every three years and is unannounced. The purpose of the survey is to evaluate the clinic's compliance with the federal Medicare guidelines and conditions of participation. There were no citing's or deficiencies and the certification was recommended for renewal.

The practice was recently invited by the account representative for Humana, to join the plan's Path to Value Engaged Contract that offers incentivized payment structures for closing gaps in quality. The representative noted that Roanoke Clinic was the first practice in the region to be offered the contract. He said Humana had been monitoring the practice "behind the scenes" for approximately two years and noted that out practices and outcomes "…were well ahead of the curve, as compared to other practices, with quality work." The team also learned that Humana had been performed a member experience survey to the assigned Humana patients attributed to our practice. The scores were very impressive with a rating of 98.1%. See Attachment 4. The representative noted that this was the highest score he'd seen since joining the Humana team. Humana had also been following the practice's STAR ratings and HEDIS scores, with regards to closing the gaps in quality metrics, and the representative complimented the practice's efforts. Over the last two years, Roanoke Clinic has earned approximately $16,000 in incentive payments from Humana for closing gaps in care. The new Path to Value Engaged Contract will add approximately 15 quality metrics, of which the practice is already scoring 4-5 stars on most of the included measures.

The incentive payment structure is a per patient/per measure reward for completion of the quality work. Humana is a managed care form of Medicare, so the target population is very similar to those patients included in the grant work. This recognition from Humana will be used as a means to initiate conversations with other insurance commercial companies, such as United Health Care (UHC), to reevaluate contracts and potentially receive similar incentive payments. On average, the practice has earned approximately $13,000 per year from UHC for closing gaps in care. The intent is to use the extra payments to not only support the sustainability of the grant program after the funding ceases but to also immediately support the difference in salaries of the two medical assistant positions (that were originally in the plan to add to the team in year two) and the salaries of two panel manager positions that would be a great benefit to the efforts of the grant program.

Project Impact

a.) How do you define "success" for your grant program? Please bold/highlight your selection. You may choose more than one option. If other, please describe.

a. Access to a new or expanded health service-

The leadership team worked with physicians and advanced practice providers in the practice to create an open schedule template with only one appointment type. This change improved access and has further decreased emergency room utilization.

b. Increased number of people receiving direct services
c. Improved quality of health services-

As mentioned above, insurance companies have begun to recognize and incentivize the practice because for marked improvement in quality scores.

d. Operational efficiencies or reduced costs-

Proven decline in ER visits and hospital readmissions.

e. Integration of process improvement into daily workflow
f. Continuation of program activities after grant funding
g. Continuation of network or consortium after grant funding
h. Health improvement of an individual
i. Health improvement among your program participants
j. Health improvement among your community
k. Enhanced staff capacity, new skills, or education received
l. Improved capacity to adapt to changes in healthcare
m. Other (please describe)

b.) How has the federal funding of your grant program increased local capacity at your organization, within your network, and/or in your community? Please bold/highlight all that apply. If other, please describe.

a. Formalized networks or coalition-

The case managers and panel managers have joined several collaborative groups that span the hospital and community. One is the community case management group which is represented by a clinical psychologist; mobile EMT personnel; case managers from Rural Health Group (RHG), the local Federally Qualified Health Clinic (FQHC); and case managers from the hospital.

This group discusses vulnerable, at-risk patients in the community to determine whether recommendations can be obtained or other resources can be provided that haven't been explored. Another group the team participates in is the High-risk Readmission group at Halifax Regional. All readmissions are reviewed to determine the cause and discuss solutions. Missed opportunities or recommended work flow changes pertaining to Roanoke Clinic are communicated back to the team.

b. Developed new partnerships or relationships
c. Enhanced skills, education, or training of workforce
d. Enhanced data collection and analysis
e. Other (please describe)

c.) Please provide a story or two about how your program made a difference in individuals' lives or your community *(please do not use actual participant names).*

1. A 75 year old female was called by the panel manager for her monthly CCM check-in. During the conversation, the patient mentioned that she "just didn't feel good." The nurse was able to obtain more history and speak to her primary care provider about the new symptoms of fatigue and dizziness. The patient was advised to go to the emergency room where she was (newly) diagnosed with hypotension (BP 88/69) and hypokalemia. She was given IV fluids and her potassium was replenished. The phone call prevented the symptoms from progressing and the patient from developing more, potentially serious conditions such as including falls from the dizziness and/or heart arrhythmias from the electrolyte imbalance.

2. A 66 year old male, who was a double amputee, lived alone and wished remain independent; but was struggling to figure out how he could care from himself. Despite several, recent readmissions to the hospital; he was repeatedly discharged home (likely due to his personal preference). His assigned panel manager was able to connect with case management of the hospital to "flag" his chart and monitor him more closely. More importantly, the panel manager also connected the patient with the mobile EMT service to perform regular home visits to assess his environment and/or alert the practice of any safety concerns.

3. During a routine check-in call with a CCM patient who was legally blind and lived alone; the panel manager learned the patient was taking his medication by memory (opposed to following the indications from the provider). The patient told her that he would have someone arrange the bottles in a line along his counter at the beginning of each month, so he would remember how to take the pills. He stated that 'the third bottle was his blood pressure pill and the second bottle was his diabetes medicine that needed to be taken twice per day.' The panel manager worked with the patient to change pharmacies and transfer his refills. The new pharmacy offers pre-packaged blister packs with his medication already prepared and delivers his medications for free.

4. One of the panel managers found a local program for senior citizens that offered lunch (meals) for 50 cents. She connected one of her patients with the program, because the more familiar program, Meals on Wheels, had a waiting list (several months long) and the patient was skipping meals to afford her medication.

Quality Improvement

a.) In what ways has your project demonstrated advances in quality improvement during this *previous grant period (August 1, 2017 – July 31, 2018)?* Would you consider this as an innovative or best practice? If so, why?

Quality improvement, at its very core, requires a team effort. Roanoke Clinic has undergone a transformation of the team through which individual groups are setting goals, developing new strategies to complete the work and reporting on progress. It was very rewarding to watch the Medical Director's panel manager and medical assistant set small goals around quality metrics and witness the satisfaction on their faces when the goal was achieved. That team worked on uncontrolled diabetic patients and reduced the numbers on A1C's by several points. Every time they reached a goal, they would move their benchmark and keep working until their results were optimal. Each provider's team is sharing results at the clinic staff meetings. Each discipline has been challenged to set goals and is accountable to report back to the entire team. This approach is very effective and innovative. Data from internal patient satisfaction surveys are usually a good indicator of how effective quality improvement efforts are across all areas. See Attachment 5. The scores improved on almost every category between years 2016 and 2017. The representative from Humana Insurance didn't share exact numbers, but echoed the same results with patient satisfaction surveys conducted to their members attributed to our practice.

The team has also focused efforts to educate providers and clinical staff on the STOP Act (Strengthen Opioid Misuse Prevention); updated the policy on prescribing controlled substances; and are performing random chart audits to ensure compliance. Training on controlled substances and/or pain control has been provided at almost every monthly staff meeting during the 12 months. One example of improvement is with documenting post-procedural pain assessments. The baseline was 32% compliance in January 2018 and scores have increased to 95% compliance by the end of March 2018.

Another example of quality improvement is in response times to messages and/or clinical results. The leadership team noticed that the number of tasks in the staff inboxes was increasing and messages were being left for several days. The practice's commitment to patients is to acknowledge all phone calls within four hours. The case manager began monitoring the boxes daily and emailing the nursing staff about the numbers. Transparency with the information drove the numbers from 150 (or more) messages each day down to roughly 30-40 messages in the bucket at the start of each day. This was a significant improvement resulting from communication of expectations and accountability (for this metric).

b.) Please discuss the experiences and lessons learned from the adoption/adaption of your project's selected evidence based quality improvement model *during this previous grant period (August 1, 2017 – July 31, 2018).* Description provided *should directly relate to the evidence based quality improvement model used for project implementation* as provided in your application or the most recent HRSA approved evidence based quality improvement model identified.

The quality improvement evidence-based model that has been adopted in the practice is the NCQA Patient Centered Medical Home (PCMH). The experiences are that the team based approach is not only efficient and impactful; but also increases provider and employee satisfaction. Likewise, the lessons learned are that the team composition must be flexible to conform to the needs of the practice. The change from Certified Nursing Assistants to Medical Assistants working alongside the providers and the proposed change to have Medical Assistants in the Support Nurse roles have and will enhance patient flow and increase the efficiency of the clinical team.

c.) If there has there been any changes in the quality improvement evidence-based model selected for your grant project, please describe the change and explain rationale for the change that has occurred.

There has not been a change in the quality Improvement evidence-based model selected for the grant project.

Data Utilization & Sustainability

a.) Describe the strategies and/or methodologies leveraged for project data collection, utilization, and/or dissemination during *this previous grant period (August 1, 2017 – July 31, 2018).*

Our team has continued to use spreadsheets and graphs for tracking and monitoring Annual Wellness Visits; Chronic Care Management enrollment; Medicaid preventative visits, and other quality data. The data is shared with the providers and staff every two weeks to monitor, discuss, and improve the metrics. A separate spreadsheet continues to be used to track the eligibility and outreach data for the Medicare Annual Wellness Visits. Quality reports from the EMR are continue to be discussed with the support team from AXIA and their third party vendor to generate custom, scheduled reports to ensure complete data captured and accurate measurement. AXIA also provides productivity and financial reports that allow for better monitoring of daily operations and optimization of the EMR. Additionally, we have leveraged the opportunity to join Coastal Plains ACO that will further enhance the practice's visibility of the full spectrum of care being received by our assigned Medicare patients. The ACO utilizes software that compiles claims data that will allow the panel mangers to monitor, emergency department visits, hospitalizations, specialty visits, and ancillary services at outside organizations. The practice also works with Community Care of North Carolina (CCNC) on our assigned Medicaid patients to not only receive information similar to that provided by the ACO; but also to leverage the data captured in their provider portal to identify patients with multiple comorbidities, who have mental and/or behavioral health diagnoses, and who are classified as aged, blind, and/or disabled (ABD) who are likely more vulnerable and need more case management services.

b.) Please provide any sustainability strategies and/or activities that have been implemented during this *previous grant period (August 1, 2017 – July 31, 2018).*

Partnering with AXIA is proving to support the sustainability of our grant activities by assisting in streamlining internal workflows and automating manual processes. Enhancements such as these create more patient-facing time and improve efficiency throughout the practice. AXIA is also working with our practice to set-up and implement the functions of the Communicator module within Athenahealth. This functionality will allow the practice to set up automated campaigns for patient outreach tailored to specific chronic conditions and gaps in care. Data received from CCNC indicates that our practice has a higher percentage of patients diagnosed with a mental and/or behavioral health diagnosis compared to similar practices in North Carolina. The ability to identify these patients affords our practice the opportunity to focus efforts to better impact and improve the health of our assigned Medicaid population. Training on the ACO system began in April 2018. Our team is optimistic that this system will both streamline processed related to closing gaps in care by identifying services such as diabetic eye exams and specialty services received from outside facilities; and enhance documentation of hierarchical chronic conditions (HCCs) to ensure reflection of accurate risk adjustment factor (RAF) scores.

c.) How do these noted approaches to data and/or sustainability contribute to the accomplishment of project goals and program sustainability?

Reports from Axia will streamline processes for the nurse and allow her to close the gaps more efficiently. The team will continue to look for opportunities to reduce overall spending and the cost to care for high-risk patients. Additionally, the recognized need for behavioral health services has inspired one of our Nurse Practitioners to pursue a Post-Master's certificate to become a Psychiatric Mental Health Nurse Practitioner. She was accepted into the program at the University of North Carolina in April 2018. This certification will allow for better management of this patient population in the primary care setting.

Collaboration & Capacity Building

a.) Has your organization been able to leverage new partnerships, directly or indirectly, as a result of this grant project? If so, please describe how your organization has leveraged this collaboration and any implications it may have on those served through this grant project.

Rural Health Group (RHG), the local FQHC had previously joined an ACO, but quickly realized that their practice needed significant improvements in documentation to more accurately reflect their Risk Adjustment Factor (RAF) scores and decided to back-out. The CEO at that time shared data and invited our clinical team to formal training on documentation of hierarchical chronic conditions (HCCs) to reflect more accurate RAF scores. A different ACO, Coastal Plains ACO, approached RHG, the hospital, and Roanoke Clinic. All groups joined the ACO. Despite RHG being a silent competitor of Roanoke Clinic, working together places both groups at an

advantage to better manage patients who float between organizations; prevent over-utilization of resources and reduce the overall cost to care for the patient.

The practice has also partnered with Halifax County EMS and a mobile EMT program for a paramedic to perform home visits and facilitate checks to prevent patients from misusing the emergency room. These tasks include but are not limited to blood pressure checks, dressing changes, monthly injections of psychiatric medications, diabetic education and safety assessments.

> *Example: Includes development of partnerships and/or development of a new exchange within new or existing partnership(s) as a direct or indirect result of funded grant project activities. Partnership(s) can include any form of partnership, collaboration, agreement and/or exchange with any type of entity, organization, individual, groups of individuals, service(s) and/or affiliations such as, but not limited to, hospitals, local health departments, national action organizations, community ambulatory services, primary care associations, primary care provider(s), specialty provider(s), social worker(s), telemedicine service(s), specialty care service(s), insurance providers, accountable care organizations, etc.*

b.) Consortium Members *(if applicable)* - For projects implementing grant activities as part of a network, consortium and/or partnership, please include a description of any applicable changes for this *previous grant period (August 1, 2017 – July 31, 2018*) *and/or anticipated for the upcoming grant period (August 1, 2018 – July 31, 2019)*, specifically as follows:

- Any changes to the number or participation of your program's consortium members with explanation describing reason for any noted changes.

The two additional consortium members added during this previous grant period are AXIA and Coastal Plains ACO. AXIA is a Management Services Organization (MSO) and is a branch of Novant Health. The decision to partner with AXIA was a both a strategy to approach the reporting barrier from the EMR and to leverage free consulting services. The practice decided to join Coastal Plains ACO to leverage quality data, claims data, and process improvement resources that will reduce or eliminate several manual processes for the panel managers and increase their efficiency.

- Description of any impacts on grant activities which may have resulted from any noted changes described.

AXIA has connected our practice with a third party company (J.C. Griffin, LLC) which uses a live data feed (from Athenahealth) to custom generate the quality reports that we need for the HRSA grant program. Joining Coastal Plains ACO will further enhance the practice's visibility of the full spectrum of care being received by our assigned Medicare patients. The ACO utilizes, Care Evolution, software that compiles claims data, which will allow the panel mangers to monitor, emergency department visits, hospitalizations, specialty visits, and ancillary services received by our patients from outside organizations.

Health Information Technology, Telehealth, Telemedicine & Mobile Technology

a.) Has your organization and/or participating project partners experienced a change in Electronic Medical Record (EMR) system or system version during *this previous grant period (August 1, 2017 – July 31, 2018)?* Is so, please describe the change and any implications the change may have had on project implementation. Please also describe any resolutions to challenges experienced as a result of this change and/or any requested technical assistance requested to assist with these challenges.

There has been no change in our organization's Electronic Medical Record (EMR) system during the grant period of August 1, 2017 – July 31, 21018.

b.) For projects utilizing telehealth, telemedicine and/or mobile technology for project activities, please describe any challenges, successes, innovations and/or best practices you would like to share related to your project's use of telehealth, telemedicine and/or mobile technology, if applicable.

Developing strategies to utilize telehealth and/or telemedicine and mobile technology for project activities is a goal for year three (3) of this grant. No projects of this nature have been implemented to date.

Clinical Practice Guidelines & Standards

a.) Please indicate the key primary clinical standards utilized for patient care delivery as part of your project. (*Examples of clinical guidelines include, but are not limited to, the U.S. Preventive Services Task Force, American Medical Association (AMA), American College of Physicians (ACP), etc.).*

The key primary clinical standards that our practice is utilizing for patient care delivery for our project include USPSTF, American Diabetes Association, Centers for Disease Control and CMS.

b.) Does your project use any of the Agency for Healthcare Research and Quality (AHRQ) U.S. Preventive Services Task Force Guide to Clinical Preventive Services recommendations? If yes, please specify which clinical guidelines used from these recommendations for your project.

The practice uses guidelines for Hypertension screening, tobacco screening and cessation education, depression screening and statin therapy for prevention of cardiovascular disease.

c.) Does your project use any other AHRQ tools, models, measures, guidelines and/or resources? If yes, please specify which are used and how. If there are any tools, guidelines and/or resources you would like to see available, please also include this information here.

The practice is not currently using any other AHRQ tools, but is interested in researching available resources.